LETTER TO THE EDITOR

Reply to 'The easy misuse of antidepressants during pregnancy is depressing'

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We thank Braillon and Bewley [1] for their thorough reading of our article on 'Patterns of antidepressant use during pregnancy: a nationwide population-based cohort study' [2]. Aside of the important discussion they have on antiepileptic drugs that was not the subject of our research, the main comment they emitted concerned our discussion on a 'potential undertreatment and the over-reassuring conclusion that treatment has been especially adapted'. Braillon and Bewley disagree with such arguing that 'Firstly, all prescribers should always prioritise pregnancy and drug safety. However, data to ascertain the benefit:harm ratio or guide dosing are scarce'. We believe this is not fully in line nor with their comment, nor with our discussion, even to a larger extent when they state that first-line treatment should always be Cognitive Behavioural Therapy (CBT) – even for severe depression. In the discussion of our article, we especially commented on the adequacy between existing recommendations and patterns of treatment in women taking antidepressants. Owing to the existing French recommendations, antidepressants are still the only first-line treatments to be considered for major depression [3]. As a consequence, French prescribers appear to respect the general recommendation for the management of depression, and show adaptations in it consistent with the recommendations more specifically concerning pregnancy. The discussion on undertreatment was motivated by the inability we had to identify non-reimbursed therapies, and the fact that prevalence of pharmacological treatments is far inferior to the estimated prevalence of depression in pregnant women.

Some other recommendations exist of course: the newest version of the NICE recommendation, which is still disputed, considers that CBT and antidepressants can be considered equally for the management of more severe depression [4]. Even for such, the recommendation relies on a limited amount of face-to-face evaluation, affected with a

large proportion of drop-out rate making evidence of limited strength. Braillon and Bewley refer to others that provide valuable information, namely, to the 'Comparative Benefits and Harms of Antidepressant, Psychological, Complementary, and Exercise Treatments for Major Depression: An Evidence Report for a Clinical Practice Guideline From the American College of Physicians' emitted by the American College of Physicians [5]. In this, the comparisons of antidepressants (second generation, SGA) vs. CBT concerned only three trials for a total of 432 patients, all trials being considered of 'low strength of evidence', which confirms the scarcity of the comparisons existing between these two approaches. In the pooled analysis of these trials, as Braillon and Bewley point out, the lower risk of adverse events for CBT vs. SGA appears. It is however far from significant (RR: 2.51; 95% CI: 0.4–15.5) and clearly advocates for further research. In the context of antiepileptic drugs evoked by Braillon and Bewley, the situation leading to contra-indicate valproate was far different with comparisons clearly showing that significantly safer alternatives existed (e.g. lamotrigine). And recommendations evolved only once this was found indisputable [6, 7].

We fully acknowledge that in the context of pregnancy and risk conveyed on child health, safety of treatments is of tremendous importance. We firmly believe that it should however not be outweighed against the risk conveyed by an untreated disease. Indeed, the safety matter is also to protect the child against the mother's disease and to use for this the best of available treatments. Currently, in France, this is identified as antidepressant treatment as soon as a treatment is necessary. Currently also, in France, as rightly commented by Braillon and Bewley, non-pharmacological therapies are poorly available. Even so, the fact that antidepressants are considered the best option does not mean that the recommendation should never change, that

they cannot be discussed, or that other therapeutics should not be promoted if proven efficient and safe with high strength of evidence. It only informs on expert appraisal on what is the best for patients at one moment in time, owing to existing knowledge and owing to the structure and possibilities offered by the health system. At this moment in time and in this system, SGA are considered in France the best available therapeutic option providing that a patient is adhering to this approach, as unobserved treatments will only carry a risk for no benefit. And practitioners appear to use them as recommended which is mostly what we discussed in our paper.

Aside of this discussion of our results, we fully agree with Braillon and Bewley on the need for more evaluation in the context of pregnancy and for the need to scrutinize carefully the need for each and every pharmacological treatment in this situation. But we are also convinced that overtreatment might not be feared so much that it leads to undertreatment, the consequences of which should not be neglected.

Competing Interests

There are no competing interests to declare.

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